taking on disability together

Community Referral Checklist

Please include the following documents upon submission:

- ☐ Completed referral form with release of information
- ☐ Licensed independent practitioner form
- ☐ Documentation confirming primary psychiatric diagnosis. The following documents are acceptable:
  - Previous medical record indication psychiatric diagnosis
  - Letter from psychiatrist
  - Previous history and physical exam
  - Documentation from partial care program by licensed clinician

EASTERSEALS NEW JERSEY
AUTHORIZATION FOR RELEASE OF INFORMATION FORM

I hereby authorize Easterseals New Jersey to (check one or both as it applies)
- ❑ disclose to
- ❑ request from

____
(Specify individual, agency, organization, and address)
The following information regarding (name of individual receiving services): ____

____
(Address)

____
(Date of birth) (Social Security Number)

for the purpose of ____

Dates of services ____

Information to be disclosed or requested: CHECK AND INITIAL **ONLY THOSE WHICH APPLY**

❑ ______Assessment	❑ ______Service agreement
❑ ______Behavior contract or plan	❑ ______Service plan
❑ ______Criminal history	❑ ______Social assessment
❑ ______Discharge summary	❑ ______Social security information
❑ ______Financial information/earnings	❑ ______Work adjustment training report
❑ ______Intake assessment	❑ ______Physical health assessment
❑ ______Interagency communication	❑ ______Prevocational evaluation report
❑ ______Psychiatric assessment	❑ ______Legal information
❑ ______Psychological assessment/testing	❑ ______Placement report

I understand that this may include (as applicable) information relating to acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus
(HIV) infection, behavioral health service/psychiatric care, and/or treatment for alcohol or drug abuse.

The information will be released in this format (**check** all that may apply): written verbal fax electronic other (specify)___________________________

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire within one year from the date of the signature, or on the following date, event, or condition, whichever is sooner:

____

I hereby release Easterseals New Jersey, its employees and officers from any legal responsibility or liability for disclosure of or receipt of the above information to the extent indicated and authorized.

I understand that Easterseals New Jersey may not condition services or payment on whether I sign this authorization.

I understand that there is a potential for information disclosed under the authorization to be subject to redisclosure by the recipient and no longer protected.

Signature: ____
(Individual receiving services) (Date)

____
(Or legal representative) (Relationship to individual served) (Date)

____
(Signature of witness for Easterseals) (Date)

Easterseals New Jersey
BEHAVIORAL HEALTH SERVICES

PREADMISSION PHYSICAL EXAMINATION FOR RESIDENTIAL CONSUMERS

Licensed Independent Practitioner's Certification

I examined ____ on _______________
And found him/her to be **(please circle "yes" or "no")**

- Free of communicable illness **YES** **NO**

  Mantoux Test result date: __________________________________
  (MUST BE FILLED IN)

- Not in need of skilled nursing care **YES** **NO**

- Continent of bowels and bladder or able to manage incontinence independently **YES** **NO**

Medical Diagnosis (if any):

____

____

____

Prognosis/Treatment:

____

____

____

Medication (other than psychotropic medication):

____

____

____

Health/Nutritional Needs:

____

____

______________________________ ______________________
Name of Licensed Independent Practitioner **Signature**

______________________________ ______________________
Address/Phone Number **Date**

Please file in the Pre-Admission section in the residential charts

Community Living Services Referral Form

Referral For (Please check appropriate boxes)		
☐ **ESSEX** 515 Valley Street, Suite 180 Maplewood, NJ 07040 973-313-0976, 973-313-2479 (FAX) ☐ **Residential** ☐ **Supportive Housing** ☐ **HUD**	☐ **HUNTERDON** 908-788-7580, 908-788-6760 (FAX) ☐ **Residential*** ☐ **Supportive Housing*** ☐ **ICMS**** *Res & SH refer to Essex contact info* *ICMS refer to Warren contact info*	☐ **MIDDLESEX** Please refer to Monmouth contact information ☐ **Residential**
☐ **MONMOUTH** 1215-1217 Main Street Asbury Park, NJ 07712 732-380-0390, 732-380-0391 (FAX) ☐ **Residential** ☐ **Supportive Housing** ☐ **Behavioral Health Homes**	☐ **SOMERSET** 908-722-4300, 908-722-1134 (FAX) ☐ **Residential*** ☐ **Supportive Housing*** ☐ **ICMS**** *Res & SH refer to Essex contact info* *ICMS refer to Warren contact info*	☐ **WARREN** 2083 Route 57 Washington, NJ 07882 908-689-6600, 908-689-8241 (FAX) ☐ **Residential** ☐ **HUD** ☐ **Supportive Housing** ☐ **ICMS**

Date: ______________________________________
Agency: ______________________________________
Submitted by: ______________________________________
Phone Number: ______________________________________
Name of Person Being Referred: ______________________________________
Phone Number: ______________________________________
Home Address: ______________________________________
____
____
Current Address – IF DIFFERENT FROM HOME ADDRESS: (for hospital referrals, include unit and Social Worker)
____
____

Birth date: ______________________________________
Social Security #: ______________________________________
Race/Ethnicity: ______________________________________
Gender: ______________________________________
Primary Language: ______________________________________
Marital Status: ______________________________________
Emergency Contact: ______________________________________
Phone Number: ______________________________________

1. **DSM-V Diagnosis – Code & Description**

2. **Psychiatric Institutionalization (list 3 most recent, including current)**

Name of Institution	Admission Date	Discharge Date

3. **Current Medications:**

Medication	Dose; Route; Frequency

-<u>DISCLAIMER</u>-The submission of this packet does not guarantee an interview.

4. **History of drug and/or alcohol abuse (Please give details including Last Use):**

5. **History of suicidal ideation/plans/attempts (Please include dates and details):**

6. **History of aggressive and/or violent behavior (Please give details):**

7. **Is consumer currently on KROL status (found not guilty of criminal charges due to a mental illness)?** ☐ **NO**
   ☐ **YES** If Yes, Please explain: ____
8. **Pending legal charges:**

9. **Medical (if applicable):**
   Diagnosis: ____
   Treating Physician: ____
   (Name) (Address) (Phone)
   Allergies: ____
   Smoker: ☐ **N** ☐ **Y If Yes, # of years** _________________
10. **Reason for Referral:**

11. **Resources (Please list amounts if known):**

☐ **SSI** ________________	☐ **AFDC** ________________	☐ **VA** ________________
☐ **SSD** ________________	☐ **Rent Asst** ________________	☐ **Payee** ________________
☐ **SSA** ________________	☐ **Gen Asst** ________________	☐ **Other** ________________
☐ **MLTSS** ________________	☐ **MCO** ________________	

Medicare/Medicaid #: ____________________________ **Private Insurance:**___________________________________

12. **Will special accommodations be needed to complete the assessment process?** ☐ **No**
   ☐ **Yes If yes, please explain:** ____

FOR OFFICE USE ONLY

Date Received: ______________________________________ Staff Name: ____
Date of 1st contact w/referring party: ___________________ Name of 1st contact: ________________________________
Disposition: ____
____
____

13. **Check One:**

☐ Accepted ☐ Denied ☐ Pending

Staff Signature: ____ Date: ________________________________